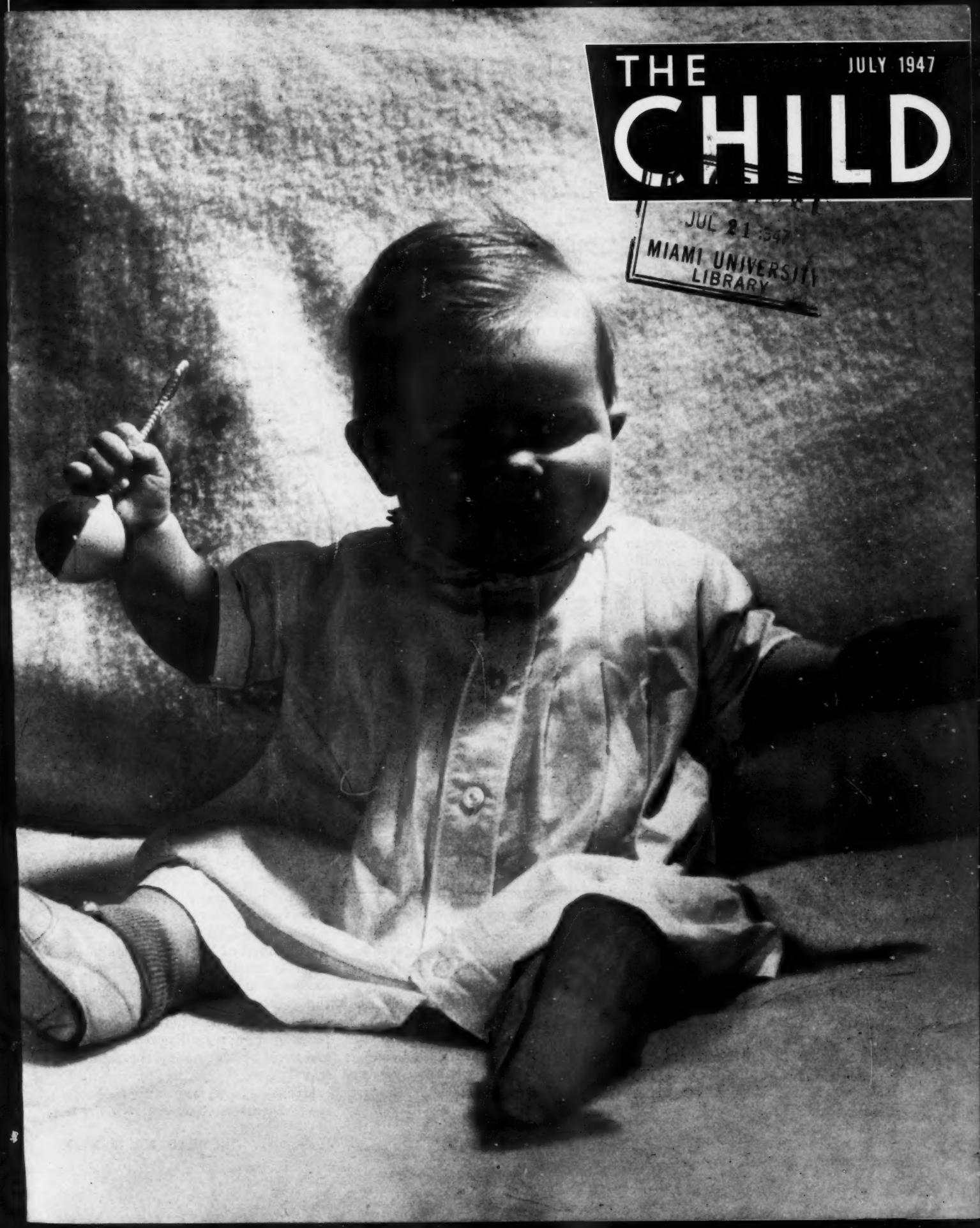


THE CHILD

JULY 1947

MEDICAL-SOCIAL WORKER HELPS BLIND BABIES TO GET GOOD START

RUTH M. BUTLER,

Medical-Social Worker, Massachusetts Eye and Ear Infirmary, Boston

IF A BLIND CHILD is to grow up to be an acceptable member of his family, of his neighborhood, and of his community, he needs mother love and a secure place in his home even more than other children do. And a first step in helping a blind baby toward a happy and useful future is to help to relieve emotional or other strains on his mother.

This may mean that the medical-social worker in a program for meeting the needs of blind children is at one time arranging hospitalization; at another, raising funds for housekeeping service when the mother is unable to attend to her home duties; or trying to place the blind child in a foster-family home; or seeking a nursery school that will accept him.

But basically it means that the worker, in trying to relieve family strains, is not only providing services for the child but is helping to strengthen the tie between the mother and the child, which may be weakened even to the breaking point by his blindness.

After a doctor diagnoses blindness in one of our baby patients, almost always the mother needs help in facing the facts and in seeing them in perspective. We try to give her this help, for unless she is able to acknowledge, both intellectually and emotionally, the fact that her baby is blind, and unless she is able to realize that his blindness is only one factor in his life, she will be unable to give him the care he should have, in the sense of fulfilling the needs of his personality.

No attempt is made to hurry the mother in adjusting herself to the difficulties she must face from now on, nor to minimize them. Instead, the case worker gives the mother continued opportunities to talk freely about her feelings and to tell of the disappointment, anxiety, and frustration she is suffering because her child cannot see.

The mother, and the father too, may at first refuse to believe that their baby is blind; and if they still refuse to believe it after a reasonable amount of explanation, the case worker may ask the doctor to explain his diagnosis to them again. She does this so that the parents will feel that it is natural for them to have many questions and doubts about their child's condition and that they have every right to discuss the situation thoroughly. If they wish to seek additional medical opinions the worker encourages them in this, so that they can feel that they have made every possible effort to give the child the best medical care.

Paper given at the National Conference on the Blind Preschool Child, March 13–15 at New York.

In developing a program to meet the needs of blind preschool children under medical care at the Massachusetts Eye and Ear Infirmary, the social-service staff has been guided by the following principles:

1. Each blind child is an individual; his particular needs should be studied, and services offered accordingly.

2. If the blind child is to make a satisfactory adjustment to his handicap, the attitude of his parents, particularly of his mother, must be recognized.

3. The blind child will find his greatest sense of security in his own home, where he has his place in the family group.

4. All community services that are useful to the seeing child, such as convalescent care, foster-home care, child-guidance clinics, and nursery-school programs, should also be available to the blind child.

5. The mother of a blind child should be offered practical assistance in training the blind; such assistance should be timed according to the mother's ability to use it.

6. Further research and study is needed: (1) To provide norms regarding the development of the young blind child and (2) to determine what can help us most in understanding his emotional growth and in finding ways of treating his problem.

If the mother demands special attention for the child in the clinic, or is critical of the hospital's methods, every effort is made to meet her demands in order that she may know that the hospital has an interest in her as an individual.

At this time the father may be more articulate concerning the diagnosis than the mother, and he is likely to ask the case worker questions to which she can give factual answers.

While the worker is discussing the diagnosis with the parents, she observes the mother's emotional reactions and judges her ability to understand the doctor's direct statement. The worker also studies the ways in which the mother either expresses or disguises her feelings about blindness and notes her responses to the case worker's own services. The worker thus picks up clues to the mother's psychological make-up, and in this way determines how she can make her services most useful.

Case worker ready to help

The case worker offers no direct advice at this time. She tries to give the mother a sense of her complete interest and sympathy, and definitely tries to gain her confidence by accepting the mother's attitude without comment even if it includes great hostility to the child. The worker points out that it may take some time before the mother can feel differently. She shows that she is aware of the many difficulties the child's condition presents and suggests that the mother come to her to discuss any disturbing situations.

As the mother begins to accept the fact that the child is blind, the case worker stands ready to help her, but only as the mother herself decides that she needs help. Several months may pass before the case worker gives the mother any service other than the opportunity to express her feelings.

Sometimes a mother is able to accept the blindness of her child with a minimum of emotional reaction. Such a mother is usually aware of the difficulties met in caring for the child, and she turns rather soon to the case worker for suggestions regarding toys, feeding, and ways of stimulating the child in socialization.

Mrs. A, aged 40, is an example of this type of mother. She was very much

disturbed about her baby's blindness, and doubted her ability to care for him. The doctor had therefore referred her to the case worker when the baby, Donnie, our patient, was 6 months old. The A's had six other children and the family relationships were excellent; Donnie had been fully accepted in the family group.

Mother's efforts successful

The case worker showed appreciation of the fine care Mrs. A was already giving Donnie, and showed that she realized that Donnie's progress was largely due to his mother's efforts. She encouraged the mother to continue his training in the sound way in which she had started, and told her she could consult the worker from time to time if problems came up.

When Donnie was almost 18 months old and could no longer be considered a baby, Mrs. A came to the hospital and told the case worker that her mother and other relatives were criticizing her for her methods of letting Donnie develop independence; for example, letting him experiment in walking, even though he would fall.

At this time Mrs. A was invited to attend a week-long educational program for mothers of blind preschool children—a summer school project. Here she found that her methods of caring for Donnie were approved by the experts at the school. As a result she was able to be more firm after she went home in holding to her own ideas even though her relatives criticized her.

The case worker suggested that a home nursery-school teacher might help Mrs. A with Donnie's training and give her instruction. Mrs. A readily accepted this service.

Mrs. A, as is usual with mothers who may be considered to be making a rather good adjustment, is aware of her own problems and of the resources she can use to meet them.

A mother who is antagonistic toward her blind child is easier to help than one who is overprotective. Regardless of how extreme the mother's antagonism may be, the case worker shows willingness to help her in any plan that seems to offer a chance that the mother may develop her latent feelings of love for her baby. If the mother requests that the baby be placed in an institution, the case worker discusses this possibility from the point of view of its meaning to the mother and the child, and in regard to the best place to send him and the length of time that she wishes him to be away from home.

One mother who requested that her baby be placed in an institution is Mrs. M. She is 24 years old, is not entirely happy in her marital relationship, and has three children under 3 years of age.

When the middle child, Jean, our patient, was 8 months old, the doctor referred Mrs. M to the case worker. During the first few months after the case worker was in contact with her, Mrs. M did not discuss Jean at all and did not seem to realize that the child was blind. She was giving the child only inadequate care, physically and emotionally, and the child was much under par physically.

Mrs. M became pregnant, and soon began to demand aggressively that she be relieved of the care of Jean, giving as her reason that she should have less responsibility during pregnancy. It was evident to the case worker that Mrs. M was strongly antagonistic to the blind child.

Since Mrs. M seemed to be unable to care properly for Jean, and since the economic status of the family was low, the case worker began to make plans to remove the child from the home.

Child-placing agency finds foster home

Great difficulty was encountered in finding a foster home that would accept a blind child. After months of effort, in which 18 different agencies were applied to, a child-placing agency finally arranged care for the child in a foster home.

The child-placing agency accepted responsibility for a long-time case-work service to prepare the mother to assume responsibility for Jean when her return home was recommended.

Jean has now been in the foster home for a year. A home nursery-school teacher visits her weekly to help the foster mother in training her. Her physical progress has been truly remarkable, and she has made some gains, but slowly, in general accomplishment.

A blind child needs mother love and secure family life even more than other children do.

Bernard's parents have always encouraged him to be active, even though he is blind.

Mrs. M now visits Jean weekly and shows some warmth for her. Whenever it is necessary for Jean to be taken to the hospital, Mrs. M accompanies the foster mother and takes responsibility for the child during the hospital visit, although at the time Jean was placed in the foster home Mrs. M wished to have nothing whatever to do with her.

In this instance it seemed desirable for the sake of the child, as well as the mother, to relieve the mother of all responsibility. It was evident that Mrs. M could not develop any feeling of warmth for Jean until she could feel that her burden was shared.

Sometimes the thinking through of actual arrangements for placing the child makes the mother aware of what giving up the child means to her, and she may withdraw her request before the plan becomes a reality.

Mrs. D, 18 years old, was one mother who did this. Mrs. D and her 3-month-old baby Jimmy came to the clinic accompanied by her husband's parents, in whose home the young couple were living. As the doctor discussed the baby's blindness the mother-in-law took complete control of the situation.

In spite of being only 18, Mrs. D showed considerable maturity in her interviews with the case worker and seemed to be capable of giving the baby adequate care. The case worker reassured her about her abilities, and Mrs. D indicated that she could care for the baby without any particular anxiety.

When Jimmy was 2, she came to the case worker, asking if there was some place where he could be placed for training. She said she did not wish to give him up, but her in-laws brought constant pressure on her in regard to his training, so that she had come to feel that his feeding and sleeping difficulties resulted from her poor care.

The case worker discussed Mrs. D's ways of handling her problems and told her that she thought her methods were sound and also that the problems she described were not restricted to a child who was blind but might be found in any child. She said to Mrs. D that it must be difficult for her to live in the home of her in-laws, and Mrs. D talked freely about the problems her living arrangements presented. The case worker spoke about the conflicts that frequently arise between grandparents and the child's own parents when both families share the same home. Before the interview was ended the case worker agreed to make arrangements for Jimmy's placement if Mrs. D was sure that this was the plan she really wished.

The mother decided to think it over, and when she returned for the next interview she withdrew her request for placement and discussed the advisability of living away from the paternal grandparents. The case worker lent support to this idea and the young couple now have a home of their own for the first time since their marriage. Jimmy is making excellent progress.

Overprotective mother difficult to help

Mothers who can only express feelings of overprotection for the blind child require a longer and somewhat more intensive treatment plan. They are likely to have strong feelings of guilt over having borne a blind child and are frequently inhibited in expressing any irritability toward the child. Such a mother cannot readily take advantage of many of the services which might be helpful to the child since she compels herself to assume complete responsibility for him.

Mrs. C is such a mother. Mrs. C was referred to the case worker when Richard, our patient, was 4 months of age. Mrs. C could think only in terms of the baby's care. She said that she was unable to enjoy any of her previous social activities because she did not feel she could leave Richard long enough to even hang her clothes in the back yard.

This mother had previously lived the life of a happy young married woman, enjoying Saturday night parties with other married couples. Therefore, the worker urged her to resume her previous recreation activities in spite of the fact that she claimed she did not now enjoy them.

When the baby was 14 months old he had to be hospitalized; and because of the mother's extreme anxiety arrangements were made for her to take a good deal of responsibility for his care in the hospital.

When Richard was 16 months old, Mrs. C was invited to join the summer-school project for mothers of blind children, but she was reluctant to do so. She was not yet ready to give up as much of the care of the baby as would be necessary in order to attend the lectures. However, when she was offered the opportunity to audit some of the lectures, she accepted. She would not be separated from Richard, but she was able to send her older preschool child to a nursery school; this gave her some relief from home responsibilities.

She has since indicated a willingness to have the home nursery-school teacher visit Richard, who is now 22 months old. Again the social worker did not insist upon the mother's use of a service before she was ready to accept it herself, but did make constant efforts to prepare Mrs. C to use the services as soon as possible.

The case worker is inclined to be fairly active in planning and offering suggestions to an overprotective mother when these activities seem to have some therapeutic value.

For example, if the case worker encourages the mother to release some of her child's care to experts, either by having a nursery-school teacher come to the home or by placing the child in a day nursery or nursery school, her approval and encouragement permit the mother to feel justified in freeing herself from some of her responsibilities.

The worker often suggests that some member of the family take more responsibility for the child, or that someone be employed to look after the child occasionally, or that the mother send the child to a nursery school even if she can only do this for one or two sessions a week.

Mother may be violently hostile

If the mother's urge to be overprotective is extreme, she cannot, of course, respond to such suggestions and will continue to take complete responsibility for the child. In such instances the case worker must be prepared to deal with rather violent expressions of hostility, which may occur when feelings of irritability toward the child are beyond the mother's tolerance point. When such feelings are expressed the mother may be shocked and frightened by her own behavior, but she can be greatly reassured if the case worker truly understands her reactions.

In dealing with a seriously malad-

justed or neurotic mother it is important for the case worker not only to recognize the condition of such a mother, but also to be aware of her own limitations in dealing with this group.

Psychiatric treatment may help

It has been our observation that it is rare for a mother to break emotionally or physically in reacting to having a blind baby. Sometimes, however, a mother shows signs of disturbance that seem to indicate that she would make a more satisfactory and quicker adjustment if the services of a psychiatrist, as well as of the case worker, could be had. However, some of the milder forms of disturbance can be handled by the case worker, under the supervision of an experienced senior worker, with an occasional consultation with a psychiatrist.

In one instance the case worker had many interviews with a mother with neurotic symptoms, whom she was unable to help. When the mother developed physical symptoms for which no organic explanation could be found, the doctor recommended psychiatry. Although the mother was reluctant to acknowledge that she was ill enough for such help, she was finally able to accept psychiatric treatment, largely as a result of the interpretation and the support which she received from the case worker. She is now under a psychiatrist's care, and she continues to see the case worker in regard to finding educational opportunities for her child.

The case-work approach is a slow-moving one, and appreciable accomplishments cannot be quickly observed. It is necessary for the case worker to be constantly flexible and ready to change her goal for the child and his family as she increases her understanding of the mother's psychology and needs.

Parental attitudes are not clear-cut, and individual parents cannot arbitrarily be placed in different categories. A case worker's evaluation of the mother's attitudes is a continuous process. The worker must be on the alert to try to understand the mother's true feelings. Otherwise, encouragement of the mother's accomplishments may force her to aim at an ideal goal which she believes is expected of her, but which in reality she could not possibly reach. If the case worker sees that her own goal for a mother has been unrealistic, she must be ready to change the goal for one which is possible for the mother.

Case work cannot effect a complete personality change in a mother, but in many instances it can bring about slight modifications of her attitude, which will enable her to make decisions and see her way out of situations which have previously seemed impenetrable.

If the mother is able to move positively toward a goal for the child and still retain her respect for her own decisions, the treatment has helped both the mother and child, irrespective of the total services offered by the agency which the worker represents.

Schooling for blind child the next step

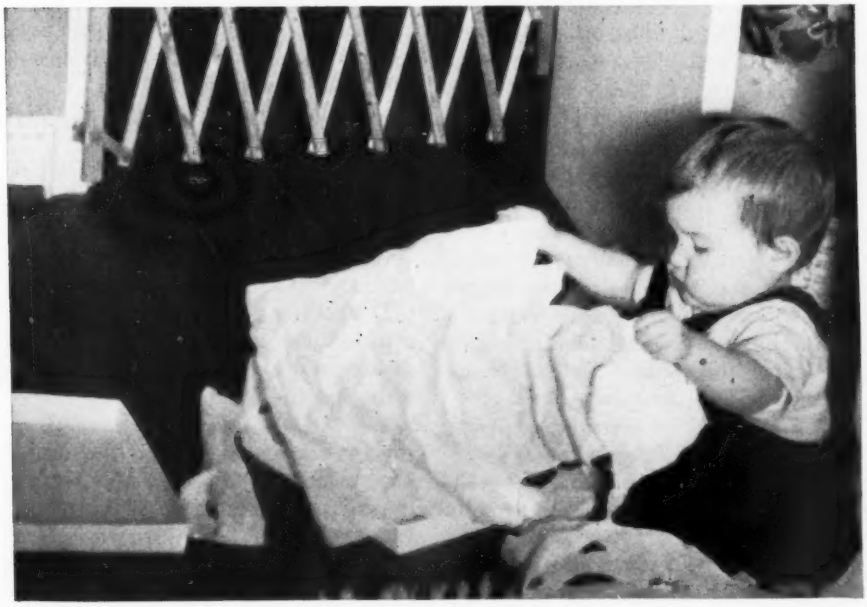
As the child approaches school age the case worker should stand ready to cooperate with educational authorities in making an academic plan which meets the needs of the particular child.

The fact that the case worker is interested in the problems of these mothers and knows about the complications that may arise in connection with blind children, and that she is available when needed, gives them a sense of confidence and security—a feeling that they are not alone. They see the case worker as a symbol of continuity of interest and of service to them. The case worker's activities in general, with mothers who can accept the blindness of the child reasonably well, may be described as a liaison service between the needs of the child and community resources.

In summary, the case workers in our Social Service Department who deal with blind preschool children and their parents try to—

1. Give the mother complete acceptance and understanding of the way she feels about her problem as she sees it.
2. Assist in developing a warm and satisfying mother-child relationship.
3. Support the mother in her own decisions regarding what is best for her child unless there is evidence that she is entirely incompetent and her decisions would be actually harmful to the child.
4. Modify unfavorable attitudes of the mothers to the extent that they may become constructive in regard to the child.
5. Use any or all of the appropriate available resources in the community to encourage the child's training and development.
6. Recognize the limitations of case work and seek psychiatric assistance for mothers and fathers with serious emotional problems.

Frances cannot see the tissue paper, but she likes to feel it and hear it crackle.



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State Plans for Maternal and Child-Health Services Show Expected Variations

Some data tabulated from plans for fiscal year 1947

CLARA E. HAYES, M. D., *Senior Medical Officer, U. S. Children's Bureau*

STATE PLANS for providing maternal and child-health services under the Social Security Act during the fiscal year ended June 30, 1947, showed as many variations as there are States. And by definition in the act, the term "State" here includes not only the 48 actual States of the Union, but also Alaska, Hawaii, Puerto Rico, and the District of Columbia. (The Virgin Islands also are now included, but were not at the time the plans for the fiscal year 1947 were prepared.)

The variations in the plans, of course, indicate the variations in the needs of the States for different types of maternal and child-health services. The Social Security Act recognizes the fact that conditions vary from State to State when it describes the purpose of the funds authorized for maternal and child-health services. The purpose, according to the act, is to enable each State to extend and improve its services, "as far as practicable under the conditions in such State."

Basically, of course, through the nature of the subject matter, the State plans resemble one another. Also a certain amount of uniformity is brought about by the fact that the Social Security Act makes certain requirements that each plan must fulfill in order to be approved.

One of these requirements, for example, is that the responsibility for administering the plan must be in the hands of the State health agency. Another is that personnel standards be maintained on a merit basis. Again, every plan must provide for extension and improvement of local maternal and child-health services administered by local health units. The act also requires that each plan provide for cooperation with medical, nursing, and welfare groups. And, in harmony with one of its expressed purposes, the act requires each plan to provide for development of demonstration services in needy areas and among groups in special need.

In every State the annual plan for maternal and child-health services is prepared by the State health agency. The services that the health agency intends to provide for the purpose of promoting the health of mothers and children in the coming fiscal year are outlined in the plan, and the estimated cost of the various items of service is given. After the State plan has been approved by the Children's Bureau the Federal funds apportioned to the State under the Social Security Act for help in carrying out the plan are paid.

We are presenting here a partial summary of the 52 State plans for maternal and child-health services for the fiscal year ended June 30, 1947.

The plans from which these summaries were made provide for the expenditure of approximately $14,000,000 of Federal, State, and local MCH funds.

These plans were made some time before Congress increased the amount authorized by the Social Security Act for annual appropriations for grants to the States for maternal and child-health services. After the additional funds were authorized, the States revised their plans accordingly, and the final plans for the fiscal year 1947 included at least $2,000,000 more than the original ones, summarized here.

Fifty percent of the total was specifically budgeted for expenditure by local health agencies. A much larger percentage than this is actually expended for local services, since many States budget as "State" expenditures all, or a major share, of the cost of MCH services actually provided in local communities.

The communities where most of the services are provided are in rural areas. Only a small proportion of the program is carried out in counties that have any city of more than 100,000 population.

As for the types of services provided for, the plans show that payments to physicians, dentists, and hospitals for services to mothers and children account for more than $1,000,000 of the year's MCH funds.

When examining these figures, the reader should remember that not all the maternal and child-health services in any State are included, but only those provided under the auspices of the State health agency. In every State many public health services for mothers and children are provided under other public auspices. And in every State private agencies provide some services.

HOW MCH UNITS ARE SET UP IN HEALTH DEPARTMENTS

In every State the plans show that the health department has a maternal and child-health unit. In all but 12 States this unit is a separate division or bureau directly responsible to the State health officer. In 7 States the MCH unit is in the health department's division of preventive medicine, in 4, in the division of local health services, and in 1, in the division of medical administration.

In 16 States the maternal and child-health director is responsible also for the crippled children's program.

MEDICAL PERSONNEL

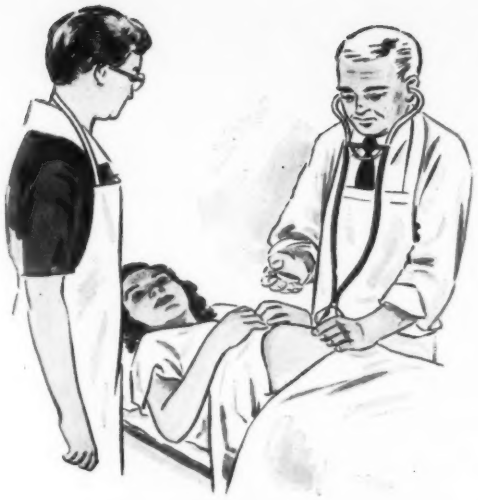
A total of 185 physicians were provided for in the 52 plans, 160 on full-time and 25 on part-time salaries.

In every State there is a State requirement that the director of MCH services be a physician; in all but one State the director gives full time to MCH services or to MCH and CC services. Three States reported the position of MCH director as vacant; in six there was an acting director at the time the plan was submitted.

Among 15 States there were positions for 18 assistant or associate directors; 6 of these positions were vacant.

In addition to these 70 positions for directors and assistant or associate directors, positions for 115 staff physicians were provided for among 36 States. These 115 positions included positions for 14 full-time and 4 part-time obstetric consultants in 17 States; 16 full-time and 3 part-time pediatric consultants in 16 States; 9 full-time maternal and child-health consultants in 6 States; 5 full-time and 1 part-time mental-

This analysis excludes all data on Emergency Maternity and Infant Care



health consultants in 5 States; 1 part-time ophthalmological consultant; 1 part-time surgical consultant; 40 full-time and 6 part-time physicians not otherwise designated in 15 States; 2 full-time and 4 part-time obstetricians in 5 States; and 5 full-time and 4 part-time pediatricians in 7 States.

Postgraduate training for 19 physicians on State and local staffs, ranging from 1 month to 1 year in duration, was provided for in the plans of 16 States. In 8 States courses of from 1 to 6 weeks duration were planned for approximately 160 practicing physicians, principally those who serve in maternity clinics or child-health conferences. (After this analysis was made, practically every State provided for greatly increased training programs for physicians, nurses, and other professional personnel.)

MEDICAL SERVICES

FOR MOTHERS

Maternity clinics.—In 38 States, according to the plans, fees were paid to practicing physicians who conduct maternity clinics. On an hourly basis the fees ranged from $3 an hour to $10 for the first hour and $2.50 to $3 for each subsequent half-hour; on a clinic basis they ranged from $5 for a 2-hour clinic to $40 for a 1-day clinic, including travel time.

Seven States allowed 50 percent higher rates for specialists who conduct clinics. One State paid part-time salaries to obstetricians for conducting clinics.

Medical delivery care.—The plans of 16 States provided for payment for delivery by a physician, usually in limited areas or for special groups such as unmarried mothers.

Obstetric consultation. — Obstetric consultation was provided for in the plans of 23 States. In 12 States this service was on a case basis, the fee ranging from $5 to $15 for consultation in the home; from $5 to $10 for consultation in office or hospital, and from $25 a day plus maintenance and travel to $25 a half day plus travel. In the other 11 States, consultants were paid part-time salaries or were full-time staff members.

FOR CHILDREN

Child-health conferences.—All but 2 State plans provided for health supervision of children through child-health conferences. Some of the conferences were conducted by local health officers and others by practicing physicians. The latter were paid on an hourly or a clinic basis. The hourly rate ranged from $2.50 an hour to $10 for the first hour, $5 being the rate most frequently paid (14 States). In general, the higher rates were paid to physicians with special training in pediatrics.

Twenty-six States made additional payment for time spent in travel, the rates varying from the usual mileage allowed State employees to 25 cents a mile.

Medical examinations of school children.—Medical examination of school children was provided for in 14 State plans. The rate of payment to general practitioners for this service was usually on an hourly or a clinic basis; the rates ranged from $3.50 an hour to $10 for the first hour and $3 for subsequent half hours, and from $6 to $10 a clinic.

Diagnostic clinics.—Provision for diagnostic service for infants and preschool children was made in the plans of 8 States, in 4 of which children of school age also were included.

Medical treatment.—Medical treatment was planned by 13 States for infants and preschool children. In 4 of these States the service was limited to 1 county; in 2 States it was limited to premature infants; in 1 to refractions; in 1 to infants of unmarried mothers; in 1 to certain cases not eligible for emergency maternity and infant care; in 1 to pediatric clinics in 3 areas; in 1 State it was limited to 1 county and given only to children under 16 years of age at monthly clinics and to children in the home; in the other 2 it was State-wide for infants in need of care.

Seven State plans provided for medical treatment for children of school age. This was limited in 3 States to 1 county; in 2 States to care of visual defects; in 1 to pediatric clinics in 3 areas of the State; and in 1 to the treatment of school-age children through local and State funds.

Medical consultation.—Consultation by physicians was provided for in the plans, by 22 States for sick infants and preschool children and by 12 States for school-age children. In 9 States the service for infants and preschool children was given by personnel of State and local health departments; in 2 by both staff and consultants in practice; in 1 State by a member of the faculty of the university medical college; in the other 10 States part-time practicing consultants gave this service and were paid on an hourly or a case basis. In 6 of the 12 States providing consultation for school-age children the service was given by the maternal and child-health staff, in 5 by consultants in practice, and in 1 State by both.

HOSPITALIZATION

FOR MOTHERS

Hospital care during delivery was provided for in the plans by 17 States. In 10 the service was on a State-wide

basis, for unmarried mothers in 8 States, and for indigent patients in 2. In the other 7 it is limited to 1, 2, or a few contiguous counties or to a few communities.

FOR CHILDREN

The plans of 13 States included provision for hospitalization of infants and preschool children. In 3 of these States this service was limited to premature infants in certain areas. In 4 States it was limited to a single county; in 3 of these States it was a demonstration service. One State provided hospitalization for infants of unmarried mothers during their first year of life; 1 hospitalized certain infants not eligible for emergency maternity and infant care; 2 States, on a State-wide basis, hospitalized infants who were medically indigent, 1 made provision for this group in all parts of the State except in cities of 50,000 or more population, and another in 4 specific areas of the State.

Provision was made by 3 of these 13 States for hospitalization of school-age children in limited areas.

HOME DELIVERY NURSING SERVICE

Home delivery nursing service was available in 16 States, the plans indicated, in 2 of which it was limited to 1 county. In the others a very small number of patients in scattered areas were given this care, and in most it was on an emergency basis only. The fees paid to graduate nurses for home delivery service on a case basis ranged from $5 for 12 hours to $15.

SERVICES FOR PREMATURE INFANTS

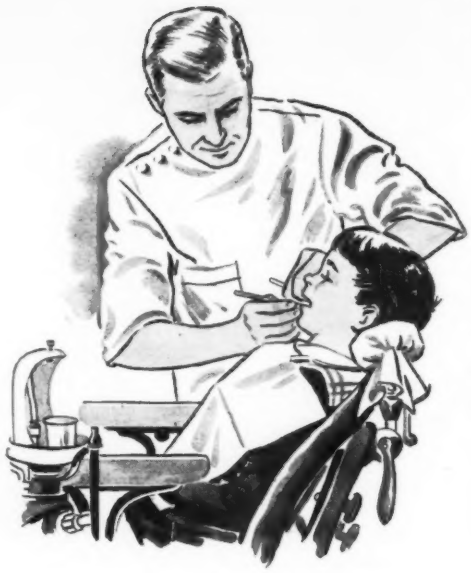
Thirty-nine States included in their plans some service, in operation, for premature infants. Of the other 13 States, 5 described services proposed for the fiscal year 1947. Eight States included no service, either in operation or proposed, for premature infants. One described no program in its plan but has recently made a survey of hospital facilities for premature infants.

In the 39 States whose plans included services for improvement of care of premature infants, the services planned ranged from such comparatively minor efforts as postgraduate training for "a few" hospital nurses, or studies of the causes of prematurity, or in-service staff training, to State-wide programs including establishment of centers for the care of premature infants, hospitalization, and medical consultation; or provision of incubators, home nursing service, and hospitalization; or hospitalization and medical consultation.

Eight States had centers for the care of premature infants already in operation. Five of these States had 1 center only, 1 State had 2, 1 had "a number throughout the State," and 1 had 48 centers. Two of these States and 6 additional States included the establishment of centers as a service proposed for the fiscal year 1947.

Other types of service provided in the interest of premature infants included postgraduate training for State and local staff physicians and nurses, in 7 States; for hospital nurses, in 8 States; in-service training for State and local staffs, in 15 States; and instruction in the care of premature infants for practicing physicians, in 5 States. Consultation to practicing physicians was made available by 5 States, and nursing service in the home by 9 States. This nursing service in the home was limited in 3 States to areas having public-health nurses (2 cities); and to 4 counties in another.

Two States had demonstration services for the care of premature infants, and 1 State proposed to establish such a service during the fiscal year 1947. In 2 States technical advisory committees on prematurity had been appointed, and in another a medical conference for premature infants was conducted in 1 county.



DENTAL SERVICE

The organization charts of 45 States show dental units. In 26 States the unit is shown as a separate division responsible directly to the State health officer. The service is in the division of maternal and child health in 10 States, in the division of preventive medicine in 6, and under local health services in 3.

A total of 100 dentists, 85 full-time and 15 part-time, and 32 dental hygienists were included in the plans of 31 State programs. Thirty dentists' and 7 hygienists' positions were vacant when the plans were submitted.

Nineteen States provided payment of fees on either a clinic or an hourly basis to local practicing dentists for educational and diagnostic services at clinics. The fees varied from $3 to $10 an hour for the first hour, and from $3.75 to $6 for each additional hour, and from $5 for a 2-hour clinic to $28 for a 4-hour clinic. One State included travel time at the same rate paid for clinic service and 6 others allowed for travel at the usual State rate. The plans of 21 States provided for corrective dental service, some at clinics in dentists' offices and other clinics, and others by the hour in dentists' offices. Payment for this service ranged from $3 to $10 an hour, and from $10 for a half-day clinic to $28 for a clinic day, with an addition of

from 50 cents an hour to $2 a clinic when dentists used their own materials.

NURSING SERVICES

The 52 State plans included a total of 331 nurses on the State health-department staffs, paid in whole or in part from MCH funds; 26 of these were directors and 6 were assistant directors; 82 were supervisory or advisory nurses. Eighty-six were consultants, including 20 consultants in maternal and child health, 6 in obstetric nursing, 2 in pediatric nursing, 24 in hospital nursing practice, 32 in public-health nursing, 1 in school health, and 1 in oral hygiene. Twenty-three were nurse-midwives, and 108 were public-health nurses not otherwise designated.

Nursing units were reported as being separate divisions responsible directly to the State health officer in 35 States. In the remaining 17 States, the nursing service was part of local health service in 12, in the division of preventive medicine in 2, under maternal and child health in 1, in the division of epidemiology in 1, and in the division of rural sanitation in 1.

Fees to graduate nurses were reported in the plans of 13 States. The rates of payment to graduate nurses for home delivery nursing service have been stated previously under "Home delivery nursing service." For postpartum care the fees ranged from $1 to $1.25 a visit, and for service at clinics, from 75 cents to $3 an hour and from $5 to $7 a clinic.

Thirty States provided postgraduate staff education for a total of 61 State public-health nurses and 87 local public-health nurses for periods varying from 2 weeks to 1½ years. Special training in obstetric and pediatric nursing, ranging in duration from 3 weeks to 2 semesters, was provided by 13 States for a total of 103 hospital nurses.

The major MCH contribution to nursing service is of course in local areas, where several thousand public-health nurses are paid wholly or partly from MCH funds.

NUTRITION

Forty-two State plans made provision for a total of 99 nutritionists on their staffs, including 9 designated as directors, 41 as consultants, and 49 as nutritionists. Another State employed a physician as director of nutrition service.

In the plans of 33 States the nutrition unit appeared in the division of maternal and child health and in 4 additional States the nutrition personnel were listed with maternal and child-health personnel. Nutrition service was in separate units responsible to the State health officer in 5 States; under local health administration in 3 States; under health education in 2 States, and under the division of preventive medicine in 1. The plans of 4 States did not give this information.

Postgraduate education was planned by 8 States for 10 nutritionists each, for periods of from 6 weeks to 1 academic year.

MENTAL HYGIENE

The plans of 14 States described mental-hygiene services in operation. In 4 of these maternal and child-health division alone conducted these services; in 3, separate mental-hygiene units within the State health departments conducted them; and in 7, mental-hygiene services were carried on by other State agencies and unofficial groups, under the supervision of the State health department. These included State psychopathic hospitals, State departments of mental health, a State board of mental hygiene, a State mental hygiene society, and a State medical college.

The MCH plans and organization charts of 11 States indicated separate units, sections, or departments of mental hygiene, 5 within the State health department, 1 in the department of public welfare; 5 were separate State departments.

Among the medical personnel previously enumerated are 6 physicians, who served in the mental-hygiene programs of 5 States, 2 as directors of mental hygiene and 4 as consultants. Four States included 5 psychologists and 3 psychiatric social workers in their programs.

New mental-hygiene services were proposed by 10 States, in 1 of which they were to be provided entirely by the maternal and child-health division, in 3 by the maternal and child-health division in cooperation with other official agencies; and in 6 by agencies other than the division of maternal and child health.

In the other State plans no mental-hygiene services were described, either in operation or proposed. In 2 of these, however, a division of mental health had recently been created within the State department of health but was not yet in operation. In 1 State a section of mental hygiene was being created within the State board of health, and in a fourth State, departments of health and welfare and community groups were preparing a plan for such services, to be submitted soon to the State health department.

MEDICAL SOCIAL SERVICE

More medical-social workers were being brought into the maternal and child-health service. Twenty-three States listed a total of 37 medical-social workers: 34 full-time workers and 3 others who divided their time between maternal and child health and crippled children's services. Of these positions, 13 were vacant at the time the plans were submitted, 12 full-time and 1 part-time. While these workers were concerned primarily with the emergency maternity and infant care program, they gave service also to the regular MCH program, and it is hoped that

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France Provides Health Services to Mothers and Children

ANNA KALET SMITH

International Cooperation Service, U. S. Children's Bureau

SINCE THE END of the Second World War in 1945, the rehabilitation of the shattered health of mothers and children in France has been a major concern for that country's Government. Although the particular needs of these population groups were recognized in France many years before the war, the facilities for safeguarding their health were admittedly insufficient in quantity and lacking in proper organization. In 1945 the Government made plans for reconstruction on a national scale of the resources for maternal and child health work, and it later placed on the newly organized Ministry of Public Health and Population the duty of transforming these plans into reality.

As a guide for carrying out this assignment an extensive body of legislation has set forth the principles and methods of a Nation-wide system of health services for mothers and children. This system, laying stress on the prevention of disease, is being gradually organized by utilizing the already existing facilities, with necessary modifications, and by developing new agencies where none exist. In this work the Ministry is aided by the social-insurance organizations, which, in France, as in other countries with well-organized social insurance, consider it financially advantageous to themselves to install facilities for preventive treatment with the aim of reducing ill health.

The organization of health work for mothers and for children under 6 years of age on a national scale was begun by the Government through a decree of November 2, 1945, and continued through regulations at various times in the next 2 years. This decree calls for division of the departments (administrative sections of the French territory) into districts. Each district must have 1 prenatal clinic for every 20,000 inhabitants and 1 child-health clinic for children under 2 years of age for every 8,000 inhabitants; also facilities for the diagnosis of tuberculosis and for the treatment of venereal disease, and a laboratory with the necessary equipment.

Protection of mothers

At the prenatal clinics a free examination is given to expectant mothers three times during pregnancy, and another within a month after confinement. The first examination, to be given before the end of the third month of pregnancy, is aimed at the detection of syphilis, tuberculosis, nephritis, heart disease, and diabetes. An X-ray examination of the lungs and a blood test for syphilis are required in every case. In the second and third examinations, given in the sixth and eighth months of pregnancy respectively, the urine is tested for albumin. Within a month after the birth of the child, the mother is required again to present herself at the clinic; this time she is given a general clinical examination, a pelvic examination, and whenever possible an X-ray of the chest.

A father must also be examined whenever this is considered necessary in view of the mother's state of health.

Treatment is available free of charge to persons covered by social insurance, who constitute an increasingly large majority of the French people.

An important element in the protection of maternal health is the maternity benefit introduced in France several years before the Second World War. Since the end of the war France has been going along with other countries, notably England, Sweden, and Soviet Russia, in expanding the maternity benefits. This was done in France under a law of August 22, 1946, so that at present the following kinds of benefits are available there:

1. Childbirth benefits, payable under specified conditions in two installments, after the birth of a child;

2. Family allowances for the second and each subsequent child, payable from the child's birth (or under certain conditions, from before the birth) until the end of the compulsory school-attendance period, and longer in some cases;

3. "Single wage" benefits for couples whose income consists of the wages of husband or wife only.

4. Prenatal benefits. The family allowances and the single-wage benefits may begin before the birth of the child. They are then called prenatal benefits and are paid from the day the pregnancy is reported to specified authorities. If the report is made during the first 3 months of pregnancy, the prenatal benefits are paid for the whole 9 months. The purpose of this is to encourage the mother to place herself under medical observation early in pregnancy.

According to a decree of March 6, 1947, the childbirth benefits may not be combined with the maternity benefits paid under the social-insurance law, and therefore the former are paid only to women who are not covered by social insurance. They are paid from the national treasury. The other kinds of benefits are limited to persons who are covered by social insurance, with the Government assuming a part of the cost. Also, the employed mothers of France benefit by the childbirth convention of the International Labor Organization, which is in effect in many countries of the world (it is not in effect in the United States). Under this convention French women are prohibited from working for a specified time near the childbirth period and, as a compensation for the loss of pay, they receive a part of their wages. This is paid by the social-insurance organizations to their members; smaller amounts are paid by the treasury to women not covered by social insurance. Nursing benefits are also provided by law.

If a woman fails to present herself for the required prenatal and postnatal examinations and to follow the instructions issued to her on the care of her own health and that of the child, she loses her right to the prenatal and childbirth benefits and to the premiums which are paid for regular attendance at a prenatal clinic. This, however, does not apply to the nursing benefits, which are canceled only in case the woman fails to take proper care of herself and

the child as she is directed to by the social workers on the staffs of the prenatal and child-health clinics, who visit the mothers in their homes.

Protection of young child's health

An important factor in the safeguarding of child life is the child-health clinic, where the health and growth of the children are watched and the mothers are instructed in their care. Such clinics existed in France before the war, but at present efforts are being made to increase their number and to expand their work. Children less than 1 year of age are brought to the clinic for examinations at specified intervals. Regular attendance is rewarded by prizes in cash and in goods.

For every child brought for the first time to the clinic a health card is issued. This card must be preserved by the parents and presented at every subsequent medical examination of the child from infancy to the end of the school-attendance period. The results of the examination and the prescribed treatment must be noted on the card, according to regulations issued in December 1946.

A social worker who finds that the benefits paid to the mother are not used for the good of the child or that a child lacks proper care must report this to the departmental director of public health. If a child seems ill, the worker advises the family to call a physician, and if her advice remains unheeded she refers the case to a physician engaged in child-health services.

For the greater effectiveness of the health work, pediatricians are to be appointed to act as technical advisers in maternal and child health to the departmental director of public health. In addition, these pediatricians may be entrusted with technical control over public agencies and private organizations engaged in maternal and child-health work. According to a decree of May 22, 1946, each pediatrician acting in such capacity must have a definite territory assigned to him; one or more associates may be appointed for him.

Annual reports on the administration of the health services for mothers and for children less than 6 years of age in each department must be presented by the prefect to the Minister of Public Health and Population. The cost of administering the services is shared by the National Government, the departments, and the communes (the smallest administrative divisions of French territory).

As an attempt to coordinate the health work for children under 6 years of age a Supreme Council of Child Welfare has been organized in the Ministry of Public Health and Population under a decree of January 8, 1947. The membership of the council includes several public-health officials, two pediatricians, and one social worker. The council studies all questions referred to it by the Ministry and serves as a liaison among the Government agencies of France that are engaged in child-welfare work.

Protection of school children's health

School children's health has been claiming public attention for many years; and school medical services have been gradually introduced in a number of cities by the municipal governments. These efforts, however, have been inadequate in organization, and have been able to take care of only a small part of the school children. Therefore the Government has undertaken, as a part of its postwar rehabilitation, to organize a Nation-wide system of health services for all school children during the entire school-attendance period.

The foundation for this work was laid down in the decree of October 18, 1945, concerning the protection of school children's health; this decree was followed a year later by regulations translating it into action.

These regulations, issued in November 1946, stress prevention of communicable diseases, particularly tuberculosis, in view of the children's undernourished condition. They require that all children between the ages of 5 and 6 years shall be vaccinated and that they shall receive a physical examination, including examination of the mouth and teeth. This plan is followed in order to allow enough time for the correction of defects before the child enters school. Parents failing to present their children for such an examination are subject to a fine or imprisonment. Conditions requiring treatment are reported to the parents.

The results of each examination are noted on an individual health card,

which is issued to each child and is kept by the school authorities while the child is attending school. After that it is turned over to the parents.

Children examined regularly

During the years of school attendance periodic examinations must be given to all school children. These examinations, like those given the child entering school, are free; but examinations by specialists and the laboratory tests are free only to children who are covered by social insurance; others must pay according to a fixed schedule.

The examinations are given by full-time or part-time school physicians. In each department these physicians are under the supervision of a chief school

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CHILDREN ARE CHIEF VICTIMS OF MIGRATORY-LABOR SYSTEM

Federal Committee Shows Way Toward Action

IN A COUNTY in the Southwest—a rural county of 5,380 square miles—a child-welfare worker was talking about her work.

"Much can be done," she said, "for this county's children. But not for the children in the cotton camps. Those families are shrugged off by the county, by the folks as well as the officials. Even the State finds the job of helping them too big. These migrants are the American untouchables! Yet these families—children included—pick the crop; without them the growers would be sunk."

"What can be done for these children?" Her thoughtful eyes seemed to look for an answer beyond her own county to the continental expanse of 48 units woven into one great people: Surely that people is equal to caring for the children who follow the million miles of criss-crossing highways, back and forth across State lines—spending their babyhood in trucks, in shacks, on the edges of fields; spending their childhood working with their parents on the crops that mature somewhere every month of the year. Following rich harvests, they lose the advantages that are supposed to accrue to American children from the Nation's agricultural and industrial wealth.

What can be done for these children who move from crop to crop?

The Federal Interagency Committee on Migrant Labor offers an answer. In a report, "Migrant Labor; a Human Problem," published by the Retraining and Reemployment Administration of the United States Department of Labor, that committee restates, in national terms, what that local child-welfare worker said about the children in the cotton camps of her county:

"A sizable segment of our population," it says, "through community and State neglect, has been robbed of so many normal American and human rights that it is almost unbelievable. Child labor, substandard living, and a padlock against education have destroyed the rights of children and drastically disturbed the integrity of family life among migrant workers. Estimates ranging from one to five million individuals comprise America's forgotten people of 1947, agricultural and industrial migrants. This equals the population of from 4 to 12 of our 48 States. Unorganized, . . . ineligible for educational, health, or welfare benefits, . . . migrants frequently find maintenance of even a minimum standard of living an impossibility."

The seriousness of the situation was recognized by the Twelfth National Conference on Labor Legislation, which was held in Washington late in 1945, representing 42 States, the District of Columbia, and Puerto Rico. This conference recommended organization of a Federal committee made up of the agencies having responsibilities toward migrant workers (these agencies are the Department of Labor, the Department of Agriculture, the Federal Security Agency, the National Housing Authority, and the Railroad Retirement Board). This committee, the conference decided, should study and report on working and living conditions and should work out a program to set standards for migrants equal to those set for other workers.

The committee was established in May 1946 under the authority of the War Mobilization and Reconversion Act of 1944. Now it has issued its report, describing actual conditions, and making recommendations in three parts: (1) Community and employer acceptance of their obligations toward migrant workers brought in for agricultural and industrial labor; (2) improved practices in recruiting, transporting, and placing migrant workers and in providing them with better housing, health, education, and welfare services; and (3) legislation, Federal, State, and local, to improve the working and living conditions of migrants.

"The chief victims in the families of migratory workers," says the report, ". . . are the children." Of the six "background discussions," which narrate the difficulties and the remedies for them, the focus for readers of *The Child* is "Child Labor and Education."

The report shows that much of the agricultural work these children do is as undesirable for them as the work that children did in factories until legislation forbade or regulated it. It shows the meagerness of current legislative protection, Federal and State, for these extremely young workers.

Frequent change from place to place makes these children feel uprooted and unwanted. Left to themselves day after day they may develop serious physical and mental difficulties. The committee recommends tax-supported day-care centers, with local people, employers, and workers joining to plan and to put thought and effort into making them work.

Specific about the education of migrant children, the report declares that not only do these children have a right to the services of schools in whatever community and State they reside in for short times, but the schools have a duty to plan services especially for these children, even though the services cost many dollars.

For example, a thorough service might mean the employment of an extra supply or reserve of teachers or tutors by State, county, or city school systems. Part of their duties would be to locate migrant children, to help them get into school, and to organize classroom groups when and where they were needed. These teachers would be educated to understand the hardships these children had suffered arising from their changing home life, their irregular schooling, undernourishment, and the fears and hostilities created by their being discriminated against in many of their temporary homes. Courses and school equipment for older pupils are also suggested.

If we Americans sincerely want to prevent a caste system from growing up based on a gross difference in education and the other necessities of childhood, the problems of the migrant family are the problems of us all.

Hilary Campbell

IN THE NEWS

California Youth Committee Studies Transient Youth

California is acutely aware of the problem of transient, migrant young people. During the war an increasing number of young workers flocked to the coast for war work, and the movement has continued and appears to be growing since the close of the war. Some are veterans who remember with pleasure their days here; others have followed their friends who are at work or in school.

Nonresident minors who get into difficulty are often passed on to the next community by officials too overburdened to handle the problems, and many hundreds are returned to their home communities in other States. San Diego, with the aid of State War Council funds, experimented in establishing a facility where these young transients could be held pending their acceptance by their own communities, whether within the State or without. The report concluded that communities, with the aid of State or Federal funds, could go a long way toward eliminating one of the most serious problems facing our Nation. It was concluded, also, that the transient problem is not only a local but also a State and Federal responsibility, requiring an intelligent and cooperative method of handling.

As the basis for a program for dealing with the young migrants, the California Youth Committee, appointed by the Governor in 1945, has received a grant of money from the Rosenberg Foundation of San Francisco to study the extent of the problem.

The plan of the study is to conduct surveys simultaneously in 14 cities on main routes into the State or in areas where present reports indicate that such youth are congregating. These are Los Angeles, San Diego, San Bernardino, Long Beach, Riverside, El Centro, Bakersfield, Fresno, Stockton, Sacramento, Redding, Salinas, Oakland, San Francisco. Information will be obtained regarding migrant or transient youth as they make contact with private and public youth-serving agencies. By repeating the census several times during the next 6 months, it is hoped that a picture of the problem can be secured, which will give the Governor and the California Youth Committee information and suggestions regarding plans for the adequate care of these young newcomers.

Mary Bishop Perry, regional consultant, Child Labor and Youth Employment Branch, Division of Labor Standards, United States Department of Labor, is on leave of absence to head the survey. Dr. Robert A. McKibben, chairman of the California Youth Committee, and Mrs. Paul Eliel, chairman of the executive committee of the Committee for the Study of Transient Youth, are working closely with the developing plans. State and local agencies dealing with youth will cooperate in the study.

Mary Bishop Perry

Kansas Council for Children Active

A Kansas Juvenile Code Commission of five members has been authorized by the legislature to study the laws of the State relating to children and to report their findings and recommendations, in the form of drafts of bills, to the Governor and the legislature by January 1949. The authorization specifies that this study and compilation of facts shall include "dependent, neglected, delinquent, emotionally and mentally disturbed children, and problems related to children in this State." The commission is also to "investigate the causes, prevention, and cure of juvenile delinquency." The sum of $12,500 was appropriated for the 2 years' work of this commission.

The Kansas Council for Children was active in the support of this and other legislation affecting children. Improvement of marital laws, the requirement that bread be enriched, and various desirable hospital and medical measures were passed. The vigilance of the council helped prevent the passage of two measures that would have separated certain work for children from the child-serving agencies. The first of these was a bill to shift the children's institutions to the State Board of Administration. The second, which perhaps would have been even more damaging, was a proposal that juvenile homicide cases be placed under the jurisdiction of the District Court.

Among other work of the Kansas Council for Children this spring was cooperation with State public and private groups in planning and executing a conference on exceptional children, to which were invited an administrator and a classroom teacher from each school system in the State, workers in social and health services, and the faculty of the teacher-training institutions.

Colorado Improves Services for Children

The Colorado Legislature in April 1947 passed a bill creating a children's code commission of five members to make a careful survey of child welfare and to report to the Governor and the general assembly by November 15, 1948. This is another step in the steady march of legislation and development of services in behalf of the children of the State.

Colorado has persistently improved its provision for services for children. After the Colorado White House Conference of 1932, the State Department of Public Welfare, with a child-welfare division, was established. As a result of State and Federal cooperation made possible by the Social Security Act of 1935, marked improvement in certain provisions for general welfare and for the health of children took place.

Ten years later, the 1942 Colorado White House Conference on Children in a Democracy adopted a report of a survey of conditions and services affecting children, which was made by 10 committees, including over 300 qualified lay and professional leaders. These studies revealed many "serious gaps in the program of the State for the protection and education of its children," such as insufficient health agencies, recreational facilities, and libraries accessible to rural youth; insufficient laws regarding supervision of the care of children in foster homes and of child adoption and placing; inadequate educational programs in the State homes for defective children and in the State reformatory, and inadequate regulation of employment of minors.

Soon after the war, interested citizens raised approximately $800 to aid the University of Colorado in a study of children's laws. The creation in 1947 of a children's code commission by act of the legislature is the next step in this ever-advancing program. The code commission is instructed to study the needs of children in matters which can be controlled or improved by legislative enactment and to consider also the existing laws, together with such "changes in the laws and additions to them as may be needed to embody the best experience on those subjects both in relation to ameliorating the conditions of children and preventing conditions which adversely affect the welfare of children." A sum of $7,000 has been appropriated for the expenses of this code commission.

Stella Scurlock

For Better Statistics on Rheumatic Fever

Noting that rheumatic fever has "vast consequences and social effects on the health of the child and the adult," the Twelfth Pan American Sanitary Conference, held at Caracas, Venezuela, has approved a recommendation that physicians be required to report cases of this disease to the health authorities of their community. The recommendation was made by the Uruguayan delegation at the suggestion of the Pan American Sanitary Bureau, as a result of a study of rheumatic fever made by the American International Institute for the Protection of Childhood.

Nebraska Legislative Council Studies Child-Welfare Laws

The Nebraska Legislature in February 1947 passed a resolution recognizing the desirability of clarifying and strengthening the State laws to protect the interests of children and to promote their welfare.

It directed the legislative council to continue its study of Nebraska child-welfare laws, to compare them with those of other States, to seek the cooperation of public and private agencies and of individuals concerned with the welfare of children, and to hold public hearings to obtain the views of those interested.

The council is directed further to report to the 1949 legislature its findings on existing laws and its recommendations for the clarification of existing laws and for new legislation needed for the benefit of children within the State.

• CALENDAR

July 14–17—Fifth International Congress of Pediatrics. New York. This international congress was to have been held in Boston in 1940, but had to be postponed because of the war. Further information from the secretary, Dr. L. Emmett Holt, Jr., Bellevue Hospital, New York 16.

Aug. 4–8—American Dental Association. Boston.

Aug. 27–29—National Association for Nursery Education. San Francisco.

Sept. 8–12—Third American Congress on Obstetrics and Gynecology. St. Louis.

France Provides Health Services to Mothers and Children

(*Continued from page 11*)

physician, who is himself responsible both to the educational authorities and the public-health authorities of the department.

The results of all examinations must be reported at definite intervals to the specified public authorities.

Special school health centers to be established

Under the regulations of November 1946, all medical and dental examinations are to be given in special "school health centers," one or more of which must be established in designated cities and towns. At least one trained social worker must be attached to each center.

Supervision over the health of the teachers and other members of the school staff who come in contact with the children was ordered to begin October 1, 1947.

A joint project

The cost of examining the children, teachers, and other members of the staffs is borne jointly by the National Government, the departments, and the communes. Aid is given by the National Government to communes for the installation of school health centers.

Annual inspection of all school buildings, public or private, must be made by the local school physician, and reports sent not later than December 31 of each year to the prefect of the department.

The school health work is administered jointly by the Minister of Education and the Minister of Public Health, with the participation of a national advisory commission, which was to be appointed under regulations issued in March 1947.

These plans and directives are being gradually put into operation with funds that were appropriated by law for the first quarter of 1947.

SOURCES:

Journal Officiel de la République Française, from October 1945 to March 1947. Bulletin Législatif Dalloz, January 1946 to March 1947; Bulletin du Ministère de la Santé Publique et de la Population, Nos. 1, 3, and 8, 1945 and 1946.

State Plans for Maternal and Child-Health Services Show Expected Variations

(*Continued from page 9*)

when emergency maternity and infant care is discontinued the medical-social personnel will remain to give full time to maternal and child-health services.

HEALTH EDUCATION

Twenty-one State plans provided for employment of a total of 27 health educators. Of these, 4 were designated as directors, 1 as an assistant director, 9 as consultants, 3 as public-health educators, and 1 as school health educator; 9 were not designated. The services of these workers vary greatly. Some specially qualified workers function entirely as school health educators, working closely with State and local departments of education, teacher-training colleges, and the public schools, in the preparation of curriculums and special materials for the improvement of health teaching. The work of others is limited entirely to public-health education, which consists of the preparation of material used through the various publicity channels and in keeping the public informed of the service and progress of public-health agencies. A third group combines these two functions.

This summary can give only a limited idea of the maternal and child-health services that the States provided for in their plans for the fiscal year 1947. It represents only such data as can be tabulated. The fascinating details of how these services are made available to the individual mother and child are given in the plans as prepared by the States. The plans show also the relation of these services to the total State and local health program.

Some of the gaps in service are due, not to lack of interest or of money, but rather to lack of trained personnel. One of the fields in which progress has been especially retarded by this condition is mental health. It is evident that a program of training is needed in a number of fields before enough competent personnel can be obtained to provide the health services that the mothers and children need.

Reprints available in about 5 weeks

FOR YOUR BOOKSHELF

WHEN I WAS A CHILD; an anthology, by Edward Wagenknecht. E. P. Dutton & Co. New York, 1946. 477 pp.

Early childhood memories, as Walter de la Mare says in his introduction to this collection of them, of people who not only are exceptional but who can write, make fascinating reading. Not only that, but they offer us a wonderful opportunity to observe the workings of children's minds. Even making allowance for the fact that such recollections are seen through the colored glass of the writer's later experiences, we get some intimate flashes of insight into what it is like to be a child—something any adult who has anything to do with children welcomes eagerly.

Forty-one authors are gathered here, representing a wide range of background. There is the lonely figure of little John Ruskin in the garden "decked . . . with magical splendor of abundant fruit, fresh green, soft amber, and rough-bristled crimson . . . clustered pearl and pendent ruby"—different from the Garden of Eden in that "in this one, *all* the fruit was forbidden." There is Middleton Murry, who "could not sleep without a knotted towel for company," to protect him from the frightful night terrors to which he was subject.

When Eric Gill's mother accused him of something he was not guilty of, he was flabbergasted. For if with one's own mother it was impossible to put the thing right . . ., what frightful things might be possible in the world outside where no sympathy and understanding could be drawn upon. . . . It seemed as though the very earth were reeling and insecure."

Marjorie Bowen gives us another picture of insecurity, that of the bewilderment of a child whose parents were separating. Of her mother she says, "When I was with her I always seemed to be naughty." Her baby sister's "sweetness and beauty were supposed to be in painful contrast to my plainness and villainous disposition." Of her father, whom she adored, she mysteriously saw less and less.

Mary Ellen Chase, recalling a New England Sunday in the nineties; Kathleen Coyle, coming home to her Roman Catholic mother a devotee of the Salvation Army, after being hospitalized in Glasgow; Lizette Woodworth Reese, evoking the very smell and taste of Christmas—the "thick, sugar-topped loaves, fat and black with raisins"; Eleanor Hallowell Abbott, explaining, from Longfellow's lap, that she liked his lines about Mr. Finney's turnip better than his "The Psalm of Life"—this is the world of childhood, with which we all need to renew acquaintance in order to narrow the gap that separates us from those for whose safety, happiness, and welfare we all work. This is "child psychology" distilled into something rich and rare.

Marion L. Faegre

YOUTH ORGANIZATIONS IN CANADA; a reference manual, by George Tuttle (1946. 27 pp. $1.50); YOUTH AND RECREATION; new plans for new times (1946. 220 pp. $1.25); YOUTH AND HEALTH; a positive health program for Canada (1946. 93 pp. $1); YOUNG CANADA AND RELIGION (1945. 114 pp. $1). Prepared for The Canadian Youth Commission. The Ryerson Press. Toronto.

This series includes also "Youth Challenges the Educators," and "Youth and Jobs for Canada," both of which were discussed in *The Child*, June 1946 (pp. 192–193).

THE BLIND, by Robert B. Irwin, LL. D. American Foundation for the Blind, 15 West Sixteenth Street, New York 11. Revised 1947. 12 pp. Includes a section on Educational Facilities for Blind Children.

Reprints Available

A limited quantity of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had free.

Avoiding Behavior Problems. By Benjamin Spock, M. D. *Journal of Pediatrics*, October 1945.

Some Observations on the Canadian Family Allowances Program. By Edward E. Schwartz. *Social Service Review*, December 1946.

Nursing Care of the Premature Infant. By Elgie M. Wallinger, R. N. *American Journal of Nursing*, November 1945.

Parental Rejection of Crippled Children. By Norman Westlund, M. D., and Adelaide Z. Palumbo. *American Journal of Orthopsychiatry*, April 1946.

Pediatrics and Public Health. By Herbert C. Miller, M. D. *News Letter of the Kansas State Board of Health*, October 1946.

THE OPERATION OF HOISTING APPARATUS. Report No. 7 on occupational hazards to young workers. Child Labor Series No. 11. Child Labor and Youth Employment Branch, Division of Labor Standards, U. S. Department of Labor. Washington, 1946. 37 pp.

This report, which was made available in mimeographed form in May 1946 by the Children's Bureau, served as the factual basis for Hazardous Occupations Order No. 7, issued under the child-labor provisions of the Fair Labor Standards Act of 1938. The investigation was made by the Bureau's Industrial Division, which under the President's Reorganization Plan No. 2 of 1946 has since become the Child Labor and Youth Employment Branch of Labor's Division of Labor Standards.

Child Study Association of America Lists Pamphlets

The following pamphlets and reprints, among others, are available from the Child Study Association of America, 221 West Fifty-seventh Street, New York 19, N. Y., at the prices indicated: Discipline Through Affection, by Arline B. Auerbach (10 cents); Discipline, What Is It? by Helen Steers Burgess (15 cents); Looking at the Comics, by Josette Frank and Mrs. Hugh Grant Strauss (20 cents); Preadolescents: What Makes Them Tick, by Fritz Redl (20 cents); The Comics as a Social Force, by Sidonie M. Gruenberg (10 cents); The Kind of Parent Teachers Like, by Irvin C. Poley (10 cents); Today's Children—for Tomorrow's World, by Arline B. Auerbach (30 cents); What Makes Good Habits? (15 cents); When Children Ask About Sex, by the staff of the Child Study Association (25 cents).

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Our new volume of *The Child*, volume 12, starts this month with a healthy, happy baby on the cover. Aiming to have every child born in the United States as fine as this one, all the States, in cooperation with the Federal Government, are providing maternal and child-health services under the Social Security Act. The photograph is by Philip Bonn for the U. S. Children's Bureau.

Other credits:

Page 3, Upper, Library of Congress photograph, by Arthur Rothstein for OWI; lower, photograph by Philip Bonn for U. S. Children's Bureau.

Page 5, photograph for U. S. Children's Bureau.

Pages 7–9, sketches by Alba Leiss.

Page 11, Library of Congress photograph, by Howard Hollem for OWI.

WILL YOU HELP?

I have just come back from Europe after looking in the faces of hundreds and thousands of big and little children. They were children in Poland, Czechoslovakia, Yugoslavia, Greece, Italy, and France. They were children who passed me on the streets, children in schools, clinics, hospitals, in war orphanages and other child-care centers.

I went to Europe to find out for the International Children's Emergency Fund what these children most desperately need. I know, now, what that is.

The children in the cities and villages of these war-stricken countries need many things, but of all their needs milk comes first. They need milk in great quantities. They need it now. Since the war, almost the only milk they have had has come from UNRRA. But UNRRA's food has already stopped coming in many places. On June 30, it will cease altogether. Unless great volumes of milk start to move from countries such as ours that are lush with supplies, there are going to be millions of children who may be brought down to starvation levels that were all too common before UNRRA started.

Milk is first; then come many other needs. Shoes, for instance. I never saw so many poorly-shod or barefoot children in a city as I saw in Warsaw. Drugs and medical equipment are seriously lacking. Children's hospitals need beds and bedding. Doctors and nurses need coats and uniforms. Almost everywhere I went I heard a plea for diapers. "Ship us bolts of cloth," one medical director asked, "and we will make up the diapers ourselves." In many places there is little or no cod-liver oil.

This is the report I brought back to the International Children's Emergency Fund. This fund was created by the General Assembly of the United Nations to be the channel through which contributions from governments and citizens can flow to the relief of children in war-stricken countries.

The fund will use its money to buy foods, medical supplies, and other things, and help these countries extend and improve their health programs for children. Because the needs are so great, a priority plan for relieving them has to be agreed on. As a step toward such a plan, I went abroad to learn what children's workers on the job say are the most urgent needs of the children.

Already the United States Congress has authorized a minimum of $15,000,000 and a maximum of $40,000,000 as this Government's contribution to the fund. A number of other countries, including Australia, Canada, New Zealand, Norway, Switzerland, and the United Kingdom have agreed in principle to support the fund and are now deciding on how much their contribution can be. After the governments have made their decisions, an appeal will be made to citizens throughout the world to open their purses and pour out their money for the rescue of the more than 3,000,000 war orphans and the many other millions of children on whom the war has left its deep scars.

I know, when that appeal is made to the fathers and mothers and children on this side of the Atlantic, there will be no hesitation, no begrudging. Even though few of our people have seen the stunted bodies, the listless spirits of the little boys and girls of Europe who need our help, our imaginations are quick and our hearts are large.

Martha M. Eliot

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